The Deposition Of:
Tonya Mooningham

Date: October 16, 2014

Derek Johnson, personal representative of Kelly Conrad Green II, deceased; Kelly Conrad Green II and Sandy Pulver v. Corizon Health Inc, Lane County, Dr. Carl Keldie, Dr. Joe Pastor, Becky Pinney, Vicki Thomas, Kirstin White, et al

Taken On Behalf Of The Plaintiffs

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON
EUGENE DIVISION

DEREK JOHNSON, personal representative of KELLY CONRAD GREEN II, deceased; KELLY CONRAD GREEN and SANDY PULVER,
Plaintiffs,
vs. No. 6:13-cv-01855-TC
CORIZON HEALTH, INC., a Tennessee Corporation; LANE COUNTY, an Oregon county; DR. CARL KELDIE, an individual; DR. JOE PASTOR, an individual; BECKY PINNEY, an individual; VICKI THOMAS, an individual; KIRSTIN WHITE, an individual; JACOB PLEICH, an individual; SHARON FAGAN, an individual; ROB DOTSON, an individual; GUY BALCOM, an individual; DONALD BURNETTE, an individual; JOHN DOES 1-10,
Defendants.

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DEPOSITION OF TONYA MOONINGHAM
TAKEN ON BEHALF OF THE PLAINTIFFS
THURSDAY, OCTOBER 16, 2014

BE IT REMEMBERED that the deposition of TONYA MOONINGHAM was taken in behalf of the Plaintiffs, pursuant to the Federal Rules of Civil Procedure before Karen Steinbock, Certified Shorthand Reporter for Oregon and Washington, on Thursday, the 16th day of October, 2014, in the law offices of Synergy Legal, 1235 SE Morrison Street, Portland, Oregon, commencing at the hour of 9:08 a.m.

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APPEARANCES

ROSENTHAL GREENE & DEVLIN
By Mr. Elden Rosenthal and Mr. John Devlin
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Appearing for the Plaintiffs;

STEWART SOKOL GRAY
By Mr. Robert Coleman
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Appearing via videoconference for the Defendants;

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EXAMINATION INDEX

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Q. Okay. And how long were you out of work between the time you left Capella and the time you joined Corizon?
A. I believe it was about two months.
MR. ROSENTHAL: Let's go off the record for one second.
(Discussion is held off the record.)
BY MR. ROSENTHAL:
Q. So, when did you -- so, how long did you say you were between jobs? You told me but I didn't write it down.
A. Two months.
Q. And did you seek employment at Corizon or did Corizon seek you out?
A. I sought them out in a Career Builder-type search, search engine.
Q. Search engine?
A. Yes.
Q. And what was it that, what was the job that you applied for at Corizon?
A. Clinical risk management analyst.
Q. And was that the job that they hired you for?
A. Yes.
Q. Had there been someone in that job before

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you took the job, or were you the first person in that position?
A. The first person in this position.
Q. Who did you talk to at Corizon about the job before you took it?
A. My supervisor, Dr. Haggard.
Q. And did Dr. Haggard indicate to you why they were creating this position?
A. I don't really recall the specifics. The position, you know, has shifted a little bit since I have taken it.
Q. Well, did you get a general idea as to why they wanted to bring you on board?
A. Yes. The role, yes.
Q. I'm sorry, my question wasn't very good. Did you get a general idea about why they wanted a new person to fill this particular role that they were hiring you for?
A. I suppose they had a need for this position.
Q. That's what I'm wondering. Did she explain to you what had changed or what their thought process was on creating this new position?
A. I don't recall exactly. Maybe it was volume.

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Q. What did you understand your job would be when you started your job?
A. Okay. I would handle patient complaints and participate on the Sentinel Event Committee.
Q. What was the date you started?
A. I believe it was March 26, 2013.
Q. Was Dr. Haggard your immediate supervisor?
A. Yes.
Q. So, let's talk about the first aspect of the job as you explained it, handling patient complaints. Could you explain that to me a little bit, please.
A. It just involves when a patient calls our compliance line to report any sort of complaint, it could be about anything, medical, primarily -- well, they are all medical complaints. I would investigate that and come up with a resolution.
Q. About how many complaints were you handling a day or a week or a month, however it's easy for you to reconstruct?
A. Well, that is hard to determine because it's going to depend on the type of contracts we have. You know, once we took on Arizona, we had more. The bigger the contract, the bigger the

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area you service, naturally, the more complaints you are going to get.
Q. Were you handling complaints from a particular geographic region?
A. All of Corizon.
Q. So, approximately how many beds was Corizon providing medical care for when you began?
A. I don't know the answer to that. It's nationwide.
Q. Was it more than 100,000?
A. I don't know the answer to that.
Q. And when you first started at Corizon, approximately how many calls were you handling a week or a month, patient complaints?
A. You know, I honestly cannot answer that. Basically the calls come in to a compliance line, which is a vendor, and then they are processed by someone else and they are given to me to specifically investigate it. So, it goes through levels before it arrives to me and I wasn't responsible for developing the reports and reporting them, how many we had monthly and that sort of thing. So I can't answer that.
Q. How many were you asked to investigate in the first month or two that you were at Corizon?

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In other words, did you have just a handful, three or four, or did you have 100? I mean, give me a ballpark as to the volume of complaints that got through the vendor to you.

A. Initially, it was slower. And then we got some new contracts that came on board, but you know, up until July, I did that role, of this year, and you know, it wasn't uncommon for me to handle maybe 20 a week.

Q. And when you would get a patient complaint, that would be some kind of written report from the vendor?

A. It wasn't a written report. It came through the vendor's system, a system.

Q. So --

A. Computer program.

Q. So, I'm just curious what depth of information you would get with the complaint. In other words, if somebody called up from Arizona and said, I didn't get proper medical care for my diabetes, would you get any other information than that, or was that all that the vendor would send you?

A. Well, it depends on the quality of the complaint the patient alleged. If that's all they

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stated, it's a verbatim account of whatever the patient states. So, sometimes yes, it would be as vague as that. So, I would send it out to the site for an investigation and try to find any gaps in care.

Q. What was the name of the vendor?

A. Boy, it's, I know the site is like My Compliance, M-Y Compliance.

Q. And you were the only person at Corizon handling these complaints?

A. Yes, in terms of the investigation now, you know, that is correct.

Q. Then, the second part of your job as you explained it to me a few minutes ago was serving on the Sentinel Event Committee, is that right?

A. Yes.

Q. And who was on the Sentinel Event Committee with you?

A. There are several members. I didn't bring a listing of the names, but there are several members, probably, most -- on average the committee involved ten members.

Q. So, was the chief medical officer of Corizon on the committee?

A. Yes.

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Q. Was the chief mental health officer for Corizon on the committee?

A. Yes.

Q. Was Dr. Haggard on the committee?

A. Yes.

Q. Was Diane Wood on the committee?

A. Yes.

Q. Can you remember anyone else that was on the committee?

A. Not specifically in relevance to this case.

Q. No, I'm just asking generally. When you started work, who else was on the committee?

A. There is several physicians. Dr. Fulks, Dr. Deghetto. I'm trying to think. And they, there is more, some that may have left at this point, too.

Q. I saw a news release that was issued, I guess by Corizon, when you were hired, and it indicated that in addition to doing clinically-related telephone call issues, that you would be assisting in the analysis of professional liability records. Is that something that you were doing from the beginning of your employment?

A. Very sporadically.

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Q. All right. And then has your job changed since you were hired?

A. Yes.

Q. In what way?

A. Well, I no longer handle patient complaints, that's not a part of my role any longer.

Q. And have you been given any new assignments?

A. Not new assignments. But I have been given more volume, if that makes sense.

Q. Is 82?

A. My capacity is --

Q. I didn't mean to interrupt you. Please finish.

A. Well, since I no longer handle patient complaints, I am open to handling more Sentinel events and PLIs.

Q. So, in the first few months when you were working for Corizon, what was your role on the Sentinel Event Committee?

A. It was basically very limited. I didn't have many cases at first. Because, well, because I didn't have the capacity to do them because the compliance line required my ultimate attention.

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A. The last ten days of care provided, the whole chart, of the chart, sorry, of the chart, I get ten pages -- not ten pages -- ten days of clinical prior to the event.

Q. So look at page 3382. So those are Corizon progress notes from Mr. Green's chart. And the day of the event was February 12, so would you have expected to receive those chart notes that are 3382 through 3385?

A. One second. What was the date of the event?

Q. February 12.

A. Yes, I would have expected to.

Q. Would you have expected to receive anything else that was in the patient's chart for that time period, like 3386, which is a mental health progress note?

A. It depends on the pertinence. I don't know exactly what the policy says as far as what all -- I know that ten days of charting prior to the event, sometimes it's present, the mental health, I think it depends on whether it's pertinent to the case.

Q. Is there any way for you to determine whether you received these pages that we have just

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looked at together?

A. If I feel as though I don't have enough information, I have the option of requesting more information from the site.

Q. Right. But I want to know, is there anyway for us to figure out now whether in fact you got the chart notes?

A. No. I mean, they are not, when the chart comes to us, it's not stamped according to how many pages we are supposed to receive, if that's what you mean.

Q. Is there a stamp that indicates the date that the chart came to you?

A. No.

Q. Now, take a look at page 3390, the last page in the packet. Now, in this particular case, Ms. Mooningham, Mr. Green was taken from the Lane County Jail to an emergency room. And my question is, is it usual for you to receive an emergency room referral form similar to this when you review a case where the patient was taken to the emergency room?

A. No, not necessarily.

Q. Do you recall whether you had an emergency room referral form in this case to look

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at?

A. I do not recall.

Q. We are having a problem on our end. The picture is frozen up so let's go off the record a second.

(Discussion is held off the record.)

BY MR. ROSENTHAL:

Q. Back on the record. So, can you hear me?

A. Yes, I can hear you.

Q. So, still looking at Exhibit 132, take a look at page 3370, please.

A. Okay.

Q. Is that type of document usually in the packet that you get when you are asked to review one?

A. Yes, it is.

Q. And then working forward to 3367 and 3368?

A. Yes, it is.

Q. So, that's a two-page report from Dr. Montoya. Is that something that you would have had at your, that you would have had when you did your review?

A. Yes.

Q. And then going forward again, page 3366,

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there is a memo from Dr. Orr, is that a document that you would have had?

A. Yes, it is.

Q. I notice the 3366 has a lot of yellow markings on it. Is that something that you would have done, or would somebody else have done that?

A. I can't recall.

Q. Is it your habit to underline and mark up your copy of these documents to help you do your job?

A. No.

Q. Then, moving, again, forward another page, page 3365, would you expect that you would have had that piece of paper?

A. Yes.

Q. And then the front page, 3364, would you have had that piece of paper?

A. Yes.

Q. Now, looking at this front page, who would have filled this out?

A. Not me, so I don't really know.

Q. When you get the documents to review, do you get them electronically or do you get them in paper form?

A. Right now, both.

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Q. Did you interview anyone?
A. No.
Q. Is it your understanding that you have the option to interview somebody if you wish to?
A. That is not my understanding.
Q. So you are supposed to do this from the paper, you are not supposed to pick up the telephone and call the HSA or call the doctor and ask any further questions?
A. That option would be available.
Q. Have you ever done that?
A. No.
Q. So then, the caption describes event. You wrote, "event analysis by the site Patient Safety Committee. See report." Is that report that you are referring to there Dr. Montoya's report?
A. I'm not sure. I don't recall.
Q. Well, is there any other report that you had?
A. No, I don't have another report.
Q. Now, the next sentence says, "most concerning parts of the review." And you wrote, "no documentation that the C spine was secured or that the inmate was placed on a backboard during

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transport." So, am I correct in interpreting this that that was what was the most worrisome to you in this situation?
A. At the time of this review, retrospectively, yes.
Q. So, that was more concerning to you at the time than the items in the next paragraph?
A. Not necessarily.
Q. Well, I'm trying to understand what you meant there. What was the most concerning part of the review to you when you prepared this report?
A. The fact that the C collar and spine weren't available.
Q. And is this something that you discussed with Dr. Haggard before putting it in your report?
A. Yes, I did.
Q. And did Dr. Haggard agree with you?
A. Yes, she did.
Q. And that was more concerning to you than the failure of PA White to diagnose a spinal cord injury?
A. No, I wouldn't say it was more concerning than that.
Q. Well, you didn't even put that in here. You didn't put in here that a concerning part of

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the review was the failure of PA White to diagnose the spinal cord injury.
A. Yes.
Q. Why?
A. I think it should have been put in there.
Q. So, what you are telling me is today if you were writing the report, you would write it differently?
A. Yes.
Q. But Dr. Haggard -- what was Dr. Haggard's position at the time you did this review?
A. Her position, particularly her title, is that what you mean?
Q. Yes.
A. Patient safety officer.
Q. So, was she the chairman of the Patient Safety Committee?
A. Yes.
Q. And did she approve this report?
A. Yes.
Q. How long had Dr. Haggard been with Corizon, to your knowledge?
A. I'm not sure. I don't know.
Q. Well, was it more than six months?
A. Yes.

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Q. Was it more than five years?
A. Yes.
Q. Well, did Dr. Haggard tell you what to put in this section and you put in what she told you to put in, or did you independently decide what to put in here?
A. I independently decided what to put in the form and she scanned over it.
Q. So, why has your opinion changed since you wrote this report?
A. Well, there is -- for one, I have more experience with these cases now. This was one of my first cases. So, I review them -- in this case, I would have reviewed it differently because the practitioner, I don't believe her behavior was intentional or reckless, as I marked on the form.
Q. We will get to that in a minute.
Do you have any more information now than you did then, or is it just a matter of looking at it for the first -- now, let me start my sentence again. My sentence wasn't going to work.
Have you been given any additional information about this situation since you wrote your review form?
A. Yes, I have.

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Q. And who gave it to you?
A. Well, in talking about the case --
MR. COLEMAN: I'm going to object to the extent it calls for attorney-client privileged communications, and instruct you not to answer that part. But if you received information from somebody else that has something to do with why you might review it differently, you can tell Mr. Rosenthal what that is.
BY MR. ROSENTHAL:
Q. So, here's my question. Have you talked with anybody about this case other than lawyers since, in the last year?
A. No, I have not.
Q. And have you seen any pictures or videos in the last year relating to this case?
A. No.
Q. You have never seen the videos from the jail?
A. I have not, no.
Q. And have you seen any reports written by the Lane County Sheriff's Office in the last year?
A. No, I have not.
Q. And has anybody read depositions to you in the last year?

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A. No.
Q. Have you read any depositions in the last year?
A. No.
Q. So, on this section that we are looking at, if you were to write this section today, tell me how it would be different.
MR. COLEMAN: Which page are you on?
MR. ROSENTHAL: I'm talking about the event analysis. Well, I'm talking about the last two paragraphs in this block that we have been looking at, which is the "what happened" block.
THE WITNESS: I think it would have been pertinent to place in here that the practitioner assessment, her assessment when she found the patient.
BY MR. ROSENTHAL:
Q. It would have been pertinent to put in here her findings when she assessed the patient?
A. Correct.
Q. In the courtroom?
A. Correct.
Q. But would you have changed any parts of the, quote, most concerning parts of the review, close quote?

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A. Let me find it.
Q. It's the last six lines.
A. I think that is concerning, but I think the most relevant and pertinent thing is that the practitioner, when she assessed the patient, her neuro exam was negative and she proceeded according to her findings.
Q. So my question is, in terms of the most concerning parts of the review, would you change it if you were writing it today?
A. No.
Q. So, let's go to the next page. So, this is the block that is "best judgment of why" and you have checked, "human error, reckless behavior choice." Now, whose reckless behavior choice does that refer to?
A. Well, the nurse -- well, not the nurse, but the provider practitioner assessing the patient, and that is who it was applying to at the time.
Q. So that's physician assistant White?
A. Yes.
Q. Okay. And this was something that you filled out back in May of 2013, is that correct?
A. Correct.

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Q. And this was approved by Dr. Haggard?
A. I don't know that she specifically saw that. I know she scanned the document, but ultimately she signed off on it, yes.
Q. All right. Now, then in the second column there is a checkmark next to the word "documentation". What does that checkmark indicate? I just don't understand how to interpret it.
A. It refers to the neuro checks that were written in the physician's orders and then not written in the progress notes.
Q. I think you said that backwards, actually. Did you mean that the PA had said there were supposed to be neuro checks and there was no order written?
A. Right, correct. You are correct.
Q. So, when you checked the box "documentation" there, you are indicating that one of the reasons there was an unfortunate tragic event for Mr. Green was because this documentation wasn't handled according to Corizon standards, is that correct?
A. No. When we review these cases, it can be documentation anywhere as a part of

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opportunities for improvement. It may not be directly related to the event.

Q. In this case --

A. But in this case --

Q. Go ahead.

A. -- it is. In this case, the neuro checks should have been followed.

Q. Well, to put this in kind of everyday English, and correct me if I misstate this, if my statement isn't right, I want you to tell me.

What I'm interpreting you telling me is that when you checked the box "documentation", it was your opinion back at the time that the failure to put the neurological check order into the order pages of the chart was a contributing factor to the tragic outcome?

A. I know it should have been done. I don't know that it, what level of contribution it played.

Q. All right. Then the third column you put a check for system defects and supplies and equipment. I take it that refers to the failure to have a backboard?

A. Yes.

Q. So, did you determine at the time that

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you did this work as to whose responsibility it was to see that there was a backboard available for the medical staff at the jail?

A. No. The CAP includes that action, which is the site's responsibility.

Q. Now, when you filled out this area of the review form, this best judgment of why, did you have an opinion as to the point in time that Mr. Green suffered his spinal cord injury?

A. I don't understand the question.

Q. Sure. So, when you were filling this form out, what was your understanding as to when Mr. Green injured his spinal cord?

A. In the courtroom.

Q. And did you have an opinion as to whether he had suffered a serious injury to his spinal cord in the courtroom?

A. Retrospectively, he obviously did, which is the time of this review. But the provider assessing the patient, she, I wouldn't have chosen a reckless behavior choice for her. I now would choose a mistake because it wasn't intentional and her exam findings didn't warrant the C collar.

Q. Well, at the time when you checked "reckless behavior" for PA White, what was the

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reckless behavior that was in your head when you checked that box back in May of 2013?

A. Well, I made a mistake and it was an error, and I was mainly looking at the outcome rather than the assessment. And I wasn't familiar at that time with the just culture tool that we have in place that defines these categories. I didn't know what these categories even meant.

Q. So you filled this without really even understanding how the form was to be interpreted?

A. Right.

Q. So, I want to ask this question again because I'm not sure that we are communicating on this. I want to know back at the time -- I understand you have got a different viewpoint now -- but back at the time when you checked the box "reckless behavior", what reckless behavior were you thinking about? What was it that you thought PA White did that was reckless?

A. You know, at the time I thought that he should have been sent to the ER immediately and I thought that the facility should have had a C collar.

Q. Okay.

A. But I didn't know the exam findings.

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Q. Why didn't you know the exam findings?

A. Because I was looking at it retrospectively rather than in the practitioner, I wasn't considering her role. I was looking at the outcome more than the findings.

Q. So, take a look at page 3382 -- no, excuse me. Thirty-three -- I'm sorry, that's the wrong page. No, that's the right page, 3382. So, you will see the lower half of that page is the chart note that PA White prepared, allegedly immediately after the events in the courtroom. And her note begins on page 3382 and continues on to page 3383. Now, you had these two pages available to you in May of 2013, when you filled this review form out, is that correct?

A. Yes. Yes, I did.

Q. And in this form, she claims that she cleared him neurologically, so I don't understand what you told me a minute ago that you didn't understand what she had done or what she claimed to have done back when you filled this form out.

A. Well, I didn't understand the definition of the term I checked, this reckless behavior choice, I didn't realize that legally it means intentional behavior, and I don't believe it was

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Q. And were you aware that she suspected that there was a possible closed-head injury?
A. Yes.
Q. And so she intentionally didn't send Mr. White to the emergency room at the hospital and she intentionally didn't order any imaging, isn't that what you meant when you checked the box "reckless behavior"?
A. No.
Q. That's not what you meant. What did you mean when you checked that box?
A. Well, I don't remember exactly, but it can mean, it could mean her, that her conclusion of her diagnosis was inappropriate, it was not the right conclusion as we know now. It can mean another human behavior, could be the fact that the site didn't have the proper equipment ready and available for situations like this.
Q. Let's go down to the next box on your form on page 3372, the risk management analysis box. So, you checked "delay failure in treatment." What did you mean by that?
A. The appropriate treatment, meaning in relationship to the outcome, the patient obviously didn't get, retrospectively didn't get the right

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treatment according to the correct diagnosis, he was misdiagnosed.
Q. And did you think at the time that that misdiagnosis was a violation of the applicable standard of care for a physician assistant who is treating a person who has just run headfirst into a concrete wall?
MR. COLEMAN: I'm going to object to the question. Instruct you not to answer. There is no foundation for the concept that she would have any idea what the standard of care is for a physician's assistant in Oregon.
MR. ROSENTHAL: All right. I would request, Mr. Coleman, that you not make speaking objections. If you are going to object and instruct your witness not to answer, that's fine. But I don't think it's appropriate for you to make a speaking objection like that.
BY MR. ROSENTHAL:
Q. Now, Ms. Mooningham, in your prior employment, were you asked to determine whether or not medical providers had acted negligently?
A. Yes.
Q. And was that one of the things that you were asked to do at Corizon?

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A. Yes.
Q. So, did you, back in 2013, conclude that PA White had acted negligently?
A. I think the patient was misdiagnosed. It wasn't negligence.
Q. What is the difference between misdiagnosis as you are using the phrase and negligence as you are using the phrase?
A. Well, misdiagnosis happens in healthcare. You know, it is unfortunate, but we go through the course of right assessments that we were supposed to do and we don't catch some things sometimes.
Q. So, when you checked the box "delay failure in treatment", what you are telling me is at the time what you were thinking was there was a mistake made but it was not negligent, is that correct?
A. Correct.
Q. So, the next box that you checked was "failure to follow up". What does that refer to?
A. I don't remember specifically. I would think just with maybe the neuro checks -- I don't remember specifically why I checked that box.
Q. Well, in this case, PA White had written in the chart that there was supposed to be

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neurological checks every one or two hours, but there were no follow-up neurological checks performed. So, is that what you were referring to by failure to follow up?
A. Yes.
Q. Now, take a look at page 3367. Now, if you will look at the entry at, it says, "approximately 11:47", do you see that?
A. Yes.
Q. I'm going to read it. It says, "deputy log indicates patient had not moved. Reported to medical. Medical, paren, nurse, question mark, not documented, close paren, asked if Green was breathing. When told he was breathing, nursing informed they would check on Green later in the day, close quote.
Then there is an entry right below that at 13:45, that says, quote, deputy log indicated deputy again informed medical, patient had not moved positions close quote. Did you find -- did you believe when you did your review that those two notes by Dr. Montoya were accurate?
A. I don't know --
Q. Well --
A. -- if they are accurate.

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A. I don't know that this page was referred to in the, the Sentinel Event Committee CAP is a, can be different than the site's CAPs. Doesn't mean that they are not following them.

Q. Where do I find the Sentinel committee's CAPs?

A. You are looking at it. The case analysis on the Sentinel Event Committee form, it says, "see list for entire CAP." So, I would take that to mean that it's all-inclusive.

Q. So, let me ask you a procedure question. After you filled out this form, what happened to it? After you filled out your two-page form, after Dr. Haggard approved it, what happened to it?

MR. COLEMAN: Objection, compound. You can answer.

THE WITNESS: Okay. Well, I take the form with -- after I fill it out, I take it to the Sentinel Event Committee and I present the case and we review it and we decide on the category. And after that, well, it's done after that.

BY MR. ROSENTHAL:

Q. Well, does the Sentinel Event Committee approve your form, or is your form simply

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information for discussion?

A. It's just information for discussion. They receive a copy of it to approve.

Q. So did the Sentinel Event Review Committee approve your form?

A. No. It's just used for presentation purposes.

Q. So, does the Sentinel Event Review Committee then prepare any kind of a document regarding what its conclusions are?

A. No.

Q. So, I want to understand what happens at the Sentinel Event Review Committee after you make your presentation. Is there a discussion?

A. Yes, there is discussion.

Q. And is there a vote on anything?

A. I don't know that it's a vote. We just discuss the category level, that is it.

Q. What do you mean by "category level"?

A. I guess you could say vote. On the form it says "cat". This was rated a category four.

Q. What form are you looking at, what page?

A. 3372.

Q. Okay.

A. So, I present the case, we discuss the

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case, and then we give it a rate, we agree.

Q. And so, your committee concluded it was a four?

A. Correct.

Q. What does four mean?

A. It just means that the care that was rendered contributed to the event.

Q. What do you mean by "contributed to the event"? Do you mean contributed to the injury?

A. It can.

Q. Well, is that --

A. Yes.

Q. Was that the conclusion of the committee in this case?

A. It was just rated as a severity level four because the patient suffered injuries that led to his outcome, and there was a delay in transferring him.

Q. So, the committee concluded it was a category four after hearing your presentation. Did the committee make any other decisions after hearing your presentation?

A. No.

Q. Did all the committee members actually see your form or at least have the opportunity to

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see it?

A. No. No.

Q. Who sees the --

A. That's not part of the process.

Q. Who sees your form other than Dr. Haggard?

MR. COLEMAN: Asked and answered. You can answer again.

THE WITNESS: No one. At this point in time, you know, no one. I review it. That's it.

BY MR. ROSENTHAL:

Q. So, what you do is you make an oral presentation but you don't give the committee the form to look at, is that what you are telling me?

A. That's correct.

Q. And do the committee members have an opportunity to ask you questions if they want to?

A. Yes.

Q. Now, do you -- did you make a recommendation to the committee about whether corrective action should be taken?

A. Yes.

Q. What did you recommend to the committee?

A. The CAP as you see it on this form.

Q. So, you recommended that a cervical

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collar and spine board be obtained by the Lane County Jail, correct?
A. Yes.
Q. And did you, so the next sentence is you wrote, quote, order for neuro checks not written in the physician orders, only written in the progress notes, close quote. What is your corrective action that you recommended?
A. I didn't really specify what they had to do about it but it's just pointing it out, these are the errors and these are the corrective actions you need to come up with.
Q. So, what corrective action did the committee come up with for this problem of neurological checks not written in the physician orders?
A. I'm not sure. Typically it involves training and education for something like that.
Q. So does the --
A. And audit.
Q. So, does the committee anywhere write down that they want a corrective action of additional training on this issue?
A. Here it is on, it's covered under "doctor orders summary".

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Q. What page are you looking at, ma'am?
A. 3366.
Q. So this is Dr. Orr's recommendation. So, did the committee adopt Dr. Orr's recommendation?
A. Yes.
Q. How do you know that?
A. Well, because it says, "see list for entire CAP." I'm taking that is what that means.
Q. So, are the three CAPs that were recommended by the Patient Safety Committee the three CAPs listed by Dr. Orr?
A. It appears that they are.
Q. Now, there is nothing in those recommendations about imaging someone before they are released by medical. In these three CAP recommendations, there is nothing about imaging, is there?
A. No, there isn't.
Q. So, did the committee have a corrective action plan relating to the failure of PA White to have any imaging done before releasing him?
A. No.
Q. Now, after -- here's a question. Did you know when you did your work as to whether or not there was x-ray equipment available at the Lane County Jail?
A. No, I didn't know.
Q. Going back to your form, 3372, the last thing on there is a checkmark by the box of A. What does that mean?
A. I can't, it's just a severity level but I can't give you specifics about it without having it in front of me to tell you what it is.
Q. Is A more severe than B or C?
A. Yes.
Q. So, you checked the most severe severity rating?
A. Yes.
Q. Now, after the Patient Safety Committee has a discussion about your report -- well, actually, let me rephrase that. Take a look at page 3369.
A. Okay.
Q. So, when is this form filled out?
A. This is a feedback form after the Sentinel Event Committee renders a decision with the category, this is sent to the site to give them feedback about the outcome of the committee.
Q. So, did you fill this out?
A. I don't think -- I don't know. At that time I wasn't completing these, this part.
Q. So, who would have done this, Dr. Haggard?
A. Yes.
Q. So, I just want to be sure I understand the process. The file came to you, you did the review, you went to the committee, you gave an oral report to the committee, the committee accepted your oral report, and then did this form get sent to the site?
A. Yes.
Q. Is there any other follow-up that your committee performed in this case?
A. No.
Q. So, how does your committee know whether the corrective action plan was followed?
A. We do not.
Q. I want to go back to your form now for a minute. And again, I want to look at page 33 -- it's the second page, 3372. Now, I know that you disagree with what you wrote now, I understand that. I'm not forgetting that, but I'm trying to go back in time to May of 2013. Did you make an effort to determine why PA White made the mistakes that she made?

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A. No.
Q. Isn't that part of the Corizon policies and procedures, that you are supposed to determine why a mistake was made so that you can fix it in the future?
A. Yes, it is. This is one of my first cases.
Q. Well, did the committee try to determine why the mistakes were made?
A. Not that I recall.
Q. Now, the committee, it wasn't one of the first cases for the committee, was it?
A. No.
Q. The committee had been in existence for years, am I correct?
A. Yes.
Q. So, the committee members knew that part of their responsibility was to determine why a mistake was made, isn't that correct?
A. Yes.
Q. But there was no discussion of that at all, is that correct?
A. There was discussion about it. It's not represented in this form.
Q. Well, tell me what you remember about the

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discussion.
A. The biggest thing was the lack of the C collar. That's what I remember.
Q. So, was there any discussion about PA White's decision to not send Mr. Green immediately to the emergency room?
A. I don't know.
Q. Prior to the time I asked for your, to be able to interview like this, to take your deposition, did you know that Mr. Green died from the complications of his spinal cord injury?
A. No.
Q. Other than conversations you have had with lawyers, and I don't want you to tell me about those, but other than conversations that you had with lawyers, did you know, was there any conversation you had about this case after the Sentinel Event Committee met and before this deposition occurred?
MR. COLEMAN: I'm just going to instruct you that that would include somebody in the PLI internally, for example, Mr. Aaron.
THE WITNESS: Right. I don't recall anyone telling me that he died, no.
BY MR. ROSENTHAL:

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Q. But my question is, is broader than that.
Other than any conversations you have had with lawyers or legal staff, have you talked with anybody, any medical people, any nursing people, any administrative people at Corizon since the Sentinel Event Committee Meeting?
A. No, I have not.
MR. ROSENTHAL: Well, I'm just about done. What I would like to do, even though we don't have a technical problem, now I'm going to ask to take a short break and consult with my partner and then we can wrap this up. We are just about done. We will go off the record for a few minutes now. Okay?
THE WITNESS: Okay.
(A short recess is taken.)
BY MR. ROSENTHAL:
Q. I want to ask some questions to wrap this up now. Okay? Can you hear me all right?
A. Okay.
MR. ROSENTHAL: Are you there, Mr. Tapia?
MR. TAPIA: Yes.
BY MR. ROSENTHAL:
Q. So, I'm going to ask you some questions. It's a bit of going back a little bit, but I want

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to summarize where we are and make sure I understand it.
So, after the site medical director and the regional director prepare their reports, they send that in to the Patient Safety Committee along with the medical chart and it's given to you to review, is that correct?
A. Yes, that's correct.
Q. And when you did your review, it was your first review, so Dr. Haggard was supervising you, correct?
A. Yes, correct.
Q. And at the time Dr. Haggard was the chief patient safety officer at Corizon, is that correct?
A. Correct.
Q. And --
A. I don't know if that's her title.
Q. But in terms of --
A. Patient safety officer, that's her title.
Q. Okay. And then after you did your review, you went over it with Dr. Haggard and she okayed it, correct?
A. Correct.
Q. Then you went to the full Patient Safety

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Committee, but you didn't give them your report in writing, you gave it orally, correct?
A. Correct.
Q. Did you give them any other documents to look at? In other words, did they have the medical chart?
A. No, they did not.
Q. So, when the patient safety --
A. It's not a practice.
Q. So, when the Patient Safety Committee met, the entire process was an oral process?
A. Yes.
Q. Okay. And when you made your report to the Patient Safety Committee, did you go through everything that is in your two-page review form?
A. Yes.
Q. And did you tell the Patient Safety Committee that you had concluded that PA White had acted recklessly?
A. No, I did not.
Q. Well, did you -- this box that we talked about, reckless behavior, did you tell the committee that, that PA White had, her actions were reckless behavior?
A. No, I did not.

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Q. Why didn't you?
A. Because I don't go over everything on the form. I just go through my narratives and the corrective action.
Q. So, who, other than Dr. Haggard, knew that you had concluded that there was reckless behavior?
A. No one.
Q. So, what is the purpose of filling this out?
A. I don't know.
Q. And there was no effort made at the committee to determine why PA White made the mistakes that she made, correct?
A. I don't remember in-depth analysis of that, no.
Q. Do you know why the Patient Safety Committee isn't given a copy of your review form to look at while you are giving your verbal report?
A. It's not a part of our practice, I don't know why.
Q. Don't you think it would be a good idea?
A. I don't know.
Q. And why wasn't the Patient Safety

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Committee given a chance to look at the patient charts?
A. It's not a practice. I don't know why they don't. Each reviewer is tasked with doing it.
Q. All right. Then, after the Patient Safety Committee listens to your report and approves it, then the only documentation is that, that one page that we looked at together, page 3369, correct, the Sentinel Event Review Committee feedback form?
A. Yes. What about it?
Q. That's the only piece of paper that is generated -- we froze up again, but I'm going to keep going verbally.
Oh, it came back.
My question is, this piece of paper, 3369, this is the only piece of paper that is generated by the Patient Safety Committee after they approve your oral report, is that correct?
A. That's correct.
Q. And to your knowledge, somebody sends this document, 3369, to the site, correct?
A. Correct.
Q. Who does it go to at the site? Does it

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go to the site medical director or the HSA? Who does it go to?
A. I'm not sure.
Q. And the committee does not do any follow-up to see whether the corrective actions are taken, is that correct?
A. That's correct. It's the site's responsibility.
Q. Is the Sentinel Event Committee the same thing as the Patient Safety Committee?
A. I don't know if it technically is or not, but it's a part of it.
Q. Which committee is it that you give your report to?
A. The Sentinel Event Committee.
Q. Is there a separate committee called the Patient Safety Committee?
A. There is not.
Q. So, when I have --
A. Not to my knowledge.
Q. So, in our discussion today, whenever I said Patient Safety Committee, you just assumed I meant the Sentinel Event Committee?
A. That's correct.
Q. All right. Has there been any change in